STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11932380	**06/04/2018**
NAME OF PROVIDER OR SUPPLIER **FOUNDATIONAL HEALTH ALF**	STREET ADDRESS, CITY, STATE, ZIP CODE **10591 BAY PINES BLVD** **SAINT PETERSBURG, FL 33708**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 - Initial Comments

Assisted Living Facility

An unannounced complaint survey (CCR#2018006241, CCR2#2018006802 and 2018007196), was conducted on at Foundational Health ALF (License #7797), an assisted living facility in St. Petersburg, Florida. There were deficiencies identified at the time of visit.

0004 - Licensure - Requirements - 58A-5.016 FAC

Based on observation, interview, and record review, the facility failed to gain prior inspection and approval from the Agency for a structurethat was in use by one of three assisted living residents. (Resident #6)

Findings included:

During interview with the Administrator on at 07:07 a.m., she stated that Resident #6 lived independently in the building separate from the licensed building.

The Administrator was under the impression that Resident #6 was an independent resident.

During interview and observation with Resident #6 on at approximately 07:30 a.m., Resident #6 confirmed that he lived in the structure separate from the licensed facility, managed his own medications, and did not receive any supervision by the facility staff.

A record review conducted on , revealed that Resident #6 had a signed assisted living residency agreement, and there was evidence that he required supervision.

Class III

0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC

Based on Record review and interview, the facility failed to provide any assistance with medications, or provide supervision for one (Resident #6) of three residents who required assistance with self-administration of medication, and supervision.

Findings included:

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During interview with Resident #6, on [redacted] at approximately 07:30 a.m., Resident #6 indicated that he was independent. He confirmed that he lived in the [redacted] structure from the licensed Facility, managed his own medications, and did not receive any supervision by the Facility staff.

During an interview with the Administrator on [redacted] at 07:07 a.m., she stated that Resident #6 did live independently in the [redacted] building from the licensed building, and that he managed his own medications.

A record review conducted on [redacted], revealed that Resident #1 had a contract for Assisted Living Residency, dated [redacted], of 2018. A review of Resident #1's most recent health assessment (AHCA Recommended Form 1823, dated [redacted]), revealed that Resident #1 was identified as an elopement risk, and required assistance with self-administration of medication.

During an interview with Resident #6's Care/Case Manager on [redacted] at 11:18 a.m., it was revealed that Resident #6 did have a history of being an elopement risk, needed assistance with medications, and was not authorized by the Primary Care Provider to manage his own medications.

Class III

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28(1-2) FS

Based on observation and interview, the facility failed to ensure that 3 of 3 residents had a staff person who could effectively communicate in the residents' native language, and failed to ensure that one (#1) of three residents was treated in a dignified manner while providing assistance with meals.

Findings included:

Upon entry, at 06:33 a.m.on [redacted], Resident #6 was observed seated outside a [redacted] structure from the licensed facility. He expressed concerns with not being able to express his needs or communicate with Staff C who works weekends alone.

During an interview with Staff C on [redacted] at 06:36 a.m., she stated that she does not speak English and was not able to provide any information about the residents at the facility. Staff C stated that if an emergency was to occur, she would call the owner. Staff C confirmed that she worked the weekend and night shift by herself, and that she worked for at least three weekends.

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During the morning meal observation on . . . . . , at 08:28 a.m. Staff C, with gloved hands, was observed assisting Resident #1with her meal. Staff C was observed going to Resident #2's . . . , cleaned Resident #2's glasses, and then returned to assisting Resident #1 with her meal without changing gloves or washing her hands. Staff C was observed touching Resident #1's straw and silverware with unchanged gloves.

During the lunch meal observation on at 12:27 p.m., Resident #1 blew out of her nose. Staff C used a gloved hand and napkin to remove the . . . . . with sthe . . . . . making contact with her gloved hands. Staff continued feeding the resident a sandwich with a fork without removing the gloves or washing and/or sanitizing her hands.

During the lunch meal observation on . . . . . , at 12:30p.m., Resident #1 was observed telling Staff C that she didn't want any more food. Staff C did not understand the resident and continued to feed the resident. The resident was observed leaning forward with her head close to the table and blocking her face with her hands telling Staff C to stop giving her foods. At the same time, Staff C pulled Resident #1's hands away from her face to feed the resident. Due to the language barrier, Staff C did not understand what Resident #1 was telling her.

On , at 12:38 p.m., the Administrator was informed and observed Staff C's continued assistance, after resident said no, and the manner in which Staff C maneuvered Resident 1's hands and head while providing assistance with meal.

Class III

0053 - Medication - Administration - 58A-5.0185(4) FAC

Based on observation and interview, the facility failed to ensure that medications for 1 of 3 residents (Resident #2) that needed to be sent back to the pharmacy were stored and locked up and not accessible to others.

Findings included:

Upon entry on . . . . . at 06:36 a.m., and during the facility tour, medications in packaging were observed in the area used for the Administrator's office. The office area was accessible from the rest of the facility.

During an interview conducted with the Administrator on . . . . . at 07:07 a.m., she identified the

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medication packages as medication not given to Resident #2 by the prior Administrator. The Administrator confirmed thatthe medications in her office were not locked, and that the office was accessible to residents and others as it was used as the primary entrance and exit for the facility.

Class III

0083 - Training - First Aid and - 58A-5.0191(4) FAC

Based on record review and interview, the facility failed to ensure that one (Staff A) of one employee who worked night shift alone, completed First Aid and , , ( ) training.

Findings included:

An interview was conducted , at 06:36 a.m .with Staff C who identified herself as the only staff who worked the night shift. Staff C stated that she has worked at the facility for three consecutive weekends.

A review of the direct care staffing schedule revealed that Staff C worked by herself on the third shift (11:00pm through 7:00am).

Record review conducted on , revealed that Staff C, a Resident Assistant, was hired on . There was no evidence that Staff C was.certified in First Aid and .

During an interview with the Administrator, conducted on at 10:28am, the Administrator confirmed that Staff C worked by herself as a Resident Assistant, and that Staff C was not certified in First Aid and

Class III

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Z814 - Background Screening Clearinghouse - 435.12(2)(b-d), FS

Based on record review and interview, the facility failed to maintain an up-to-date Background Screening Clearinghouse Roster for 5 of 6 staff selected for review. (Staff A, C, D, E and the Administrator)

The findings included:

Review of the Agency for Health Care Administration Clearinghouse Employee Roster, conducted on , revealed that five (Staff A, C, D, E and the Administrator) of six staff currently working at the facility were not included on the Agency for Health Care Administration Clearinghouse Employee Roster.

During an interview with the Administrator, conducted on at 09:52 a.m., she confirmed the absence of her name, and staff's (A, C, D, and E) names on the Agency for Health Care Administration Clearinghouse Employee Facility Roster. The Administrator confirmed that she had access to the background screening site, but did not know that she was supposed to update the roster.

Unclassified